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PRACTICE OPERATIONS

AN MGMA DATA REPORT | AUGUST 2023

RESTORING BALANCE TO PATIENT ACCESS AND MEDICAL PRACTICE OPERATIONS

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MGMA®

MGMA DATADIVE PRACTICE OPERATIONS

Elements of this data set quantify something very valuable that no other data set can capture — your patient and staff experience. Fundamental metrics like the ones below dictate how patients and staff interact with and perceive your practice. Casting light on these will help improve satisfaction rates all around, which will have positive impacts on revenue, outcomes and more:

- Hours of operation
- Appointment availability
- Wait times
- No-show rates
- Turnover
- Third-next-available appointment.

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ABOUT MGMA

Founded in 1926, the Medical Group Management Association (MGMA) is the nation's largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small, private medical practices to large national health systems, representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members' behalf on national regulatory and policy issues.

mgma.com

Introduction

Medical group practices had to innovate their way through years of the COVID-19 pandemic, and the need to reinvent and refine the business of medicine and care delivery remains just as strong in the post-pandemic era.

While fears of recession ease, healthcare providers still face intense competition for workers as turnover rates remain exceptionally high, suggesting the Great Resignation is still alive across the industry.

But new benchmarks from the ***2023 MGMA DataDive Practice Operations*** survey data set, including nearly 1,000 organizations across specialties and practice types, reveal that medical group practices are rising to the challenge, adjusting their staffing models, optimizing schedules and finding sustainable workflows to continue providing high-quality care while maintaining reasonable access to patients.

- **Turnover rates for front office staff across all practices hit 40%** in 2022, while **clinical support and business operations support staff turnover rates were 33%**.
- **Weekend hours took a hit compared to pre-pandemic levels** in 2022, likely a result of ongoing staffing shortages across the industry.
- Workflow improvements and innovations such as telehealth **helped time to third next available appointment for new patients — a key patient access metric — drop by half since 2019**, from 10 days to only five days in 2022.
- **Incentive-based revenues remained stagnant in 2022 for medical groups of all specialties**, a sign that value-based care adoption remains slow as organizations struggle to revise staffing models in existing fee-for-service (FFS) arrangements while confronting a competitive market for labor.
- **Some quality measures saw a drop in 2022**, especially in terms of hospital admission rates and emergency department (ED) utilization rates.

DATA THEMES

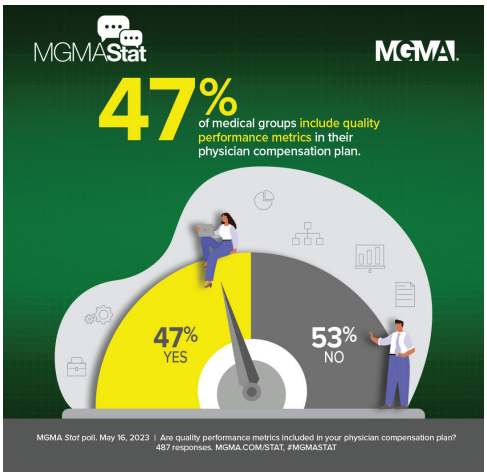
VALUE-BASED REVENUE AND QUALITY METRICS

Recovering from the impacts of the pandemic years and the subsequent strain of staffing shortages from the Great Resignation, **medical group practices did not surge ahead significantly into value-based care arrangements**, as reflected in 2022 medical revenues reported in the latest *MGMA DataDive Cost and Revenue* data set.

INCENTIVE-BASED REVENUE, AS A PERCENT OF TOTAL MEDICAL REVENUE			
	2020	**2021**	**2022**
Primary care specialties	3.42%	5.62%	2.70%
Nonsurgical specialties	0.12%	0.70%	0.77%
Surgical specialties	1.58%	0.67%	0.87%

Sources: *2021*, *2022* and *2023 MGMA DataDive Cost and Revenue*

- **Surgical and nonsurgical specialties reported only slight upticks in their relative share of incentive-based revenue**, defined as payments received from insurance companies and government agencies for incentive-based activities including pay-for-performance, risk-sharing, shared savings, quality and technology.
- While **primary care practices continue to have the largest share of incentive-based revenue** compared to their nonsurgical and surgical practice counterparts, those levels of revenue in 2022 were half of what they reported in 2021, signaling a higher emphasis on traditional FFS performance.
- This mostly stagnant trend around incentive-based revenue aligns with a similarly **slow adoption of quality performance metrics as a part of physician compensation plans**, as revealed in MGMA *Stat* polling in May 2023: Less than half (47%) of medical groups include quality metrics in physician compensation plans.



- However, that same polling from May revealed that many healthcare leaders are in the process of considering and/or adding more elements of quality in their compensation models. **"Now that we have stable volumes, we can focus more on quality performance," one respondent told MGMA.** Another respondent said that their group previously had quality performance tied to compensation before the pandemic but "took them out" of the physician compensation formula during the COVID-19 lockdowns. That group planned to bring back their quality performance component later this year. Other practice leaders said that **as contracts renew, they are taking a fresh look at how they weight existing quality performance against elements such as productivity.**

SINGLE SPECIALTY AGGREGATE RATES*		
	2021	**2022**
Hospital admission rate – for covered lives attributed under value-based contracts	1%	6%
Hospital 30-day readmission rate – for covered lives attributed under value-based contracts	11%	12%
Emergency department utilization rate – for covered lives attributed under value-based contracts	27%	35%
30-day post-operative infection rate – for covered lives attributed under value-based contracts	1%	2%

*Single Specialty Aggregate combines primary care, nonsurgical and surgical single specialty practice data.

APPOINTMENT AVAILABILITY

THIRD NEXT AVAILABLE APPOINTMENT (IN DAYS)				
	2019		2022	
	New patients	Established patients	New patients	Established patients
Primary care specialties	10	2	5	3
Nonsurgical specialties	16	7	15	11
Surgical specialties	9	6	11	7

Sources: *2020* and *2023 MGMA DataDive Practice Operations*

- **Established patients can be seen by their provider sooner than new patients by two to four days.** However, new patients are typically able to get in sooner than they were able to pre-pandemic, and the wait for established patients is a little bit longer (compared to pre-pandemic numbers).
- **More same-day appointments are available for primary care visits compared to pre-pandemic levels.**
- **Total wait times have increased by one to four minutes in the past year and are up to 7 minutes longer than they were pre-pandemic.**

PERCENT OF APPOINTMENTS THAT ARE SAME-DAY		
	2019	2022
Primary care specialties	10%	16%
Nonsurgical specialties	5%	5%
Surgical specialties	5%	4%

WHAT DOES IT MEAN?
Total wait time is defined as time in the waiting area as well as in the exam room waiting to see the provider.

NO-SHOWS, APPOINTMENT CANCELLATION AND APPOINTMENT RESCHEDULING

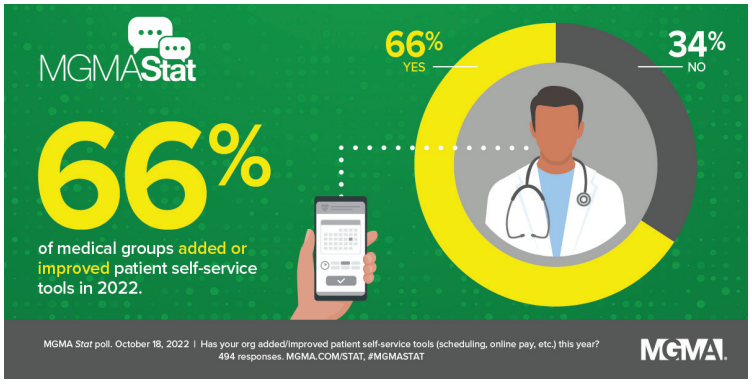
- **Practice no-show and appointment cancellation rates continue to remain lower than pre-pandemic levels.**
- Of the appointments that were canceled, by either the patient or practice/physician, the majority are rescheduled within 30 days. **Appointment reschedule rates continue to remain well above pre-pandemic rates.**

SINGLE SPECIALTY AGGREGATE RATES*		
	2019	2022
No-show rate	7.00%	5.00%
Appointment cancellation rate percentage	25.99%	11.26%
Percent of appointments rescheduled within 30 days	50.00%	79.50%

*Single Specialty Aggregate combines primary care, nonsurgical and surgical single specialty practice data.

DID YOU KNOW?

Ensuring that patients can easily get an appointment when provider schedules get strained became a tall task amid staffing shortages. An October 2022 MGMA *Stat* poll found that two-thirds of medical groups added or improved patient self-service tools in 2022. Among those that didn't, nearly 6 in 10 (59%) said they were considering upgrades in 2023.



PATIENT PORTAL USAGE

SINGLE SPECIALTY AGGREGATE PATIENT PORTAL UTILIZATION*		
	2019	2022
Schedule appointments through patient portal	10.00%	13.00%
Pay bills through patient portal	2.00%	18.50%
Access test results through patient portal	25.00%	49.00%
Communicate with providers and medical staff through patient portal	24.50%	39.00%
Download or transmit medical records through patient portal	5.99%	25.50%
Refill a prescription through patient portal	40.00%	20.00%
Fill a new prescription through patient portal	10.00%	4.00%

*Single Specialty Aggregate combines primary care, nonsurgical and surgical single specialty practice data.

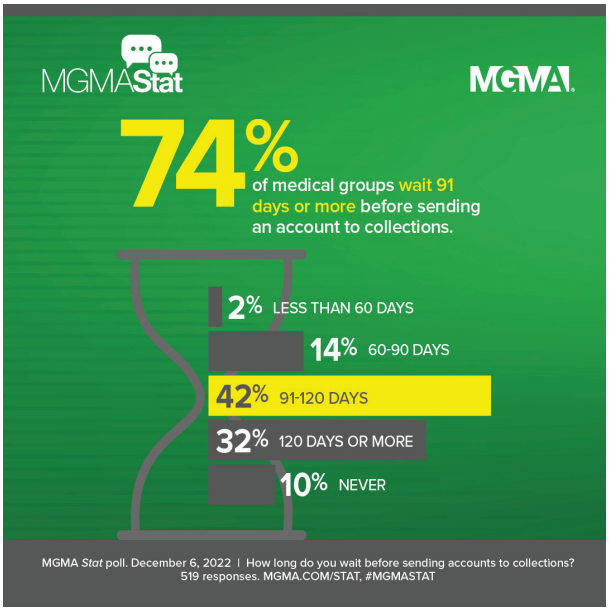
- With the exception of prescription (re)fill rates, **patient portal utilization continues to outpace pre-pandemic levels**.
- **The top uses of patient portals include accessing test results (49%) and communicating with providers/ medical staff (39%).**

BILLING AND COLLECTIONS

SINGLE SPECIALTY AGGREGATE RATES*		
	2019	2022
Percent of copayments collected at time of service	89.90%	56.00%
Percent of patient due balances collected at time of service	14.76%	39.00%
Percentage of practice claims denied on first submission	8.00%	8.00%
Charge-posting lag time between date of service and claim drop date to payer	3.8	7.75
Encounters processed per day by coding staff	75	41

*Single Specialty Aggregate combines primary care, nonsurgical and surgical single specialty practice data.

- While practices aren't collecting as many copayments at time of service, they are **doing better at collecting patient balance compared to pre-pandemic rates**.
- It's taking practices **almost four days longer to post charges for payment** compared to pre-pandemic levels.



DID YOU KNOW?

Medical practices are struggling to collect patient A/R in today's economic environment where high deductibles are common. MGMA Better Performers collect more A/R in the first 30 days compared to all practices. **Watch for MGMA's 2023 Better Performers data summary report later this year.**

OPERATIONS

- Weekday operational hours remain remained consistent year over year and compared to pre-pandemic levels. However, **primary care practices report cutting weekend availability by eight hours versus 2019 levels**.
- Throughout 2022, practices experienced **significant losses in the workforce** and have attempted to keep up with backfilling of roles.

OPERATIONAL HOURS	2019		2022	
	Week	Weekend	Week	Weekend
Primary care specialties	45	24	45	16
Nonsurgical specialties	45	48	45	48
Surgical specialties	45	*	45	*

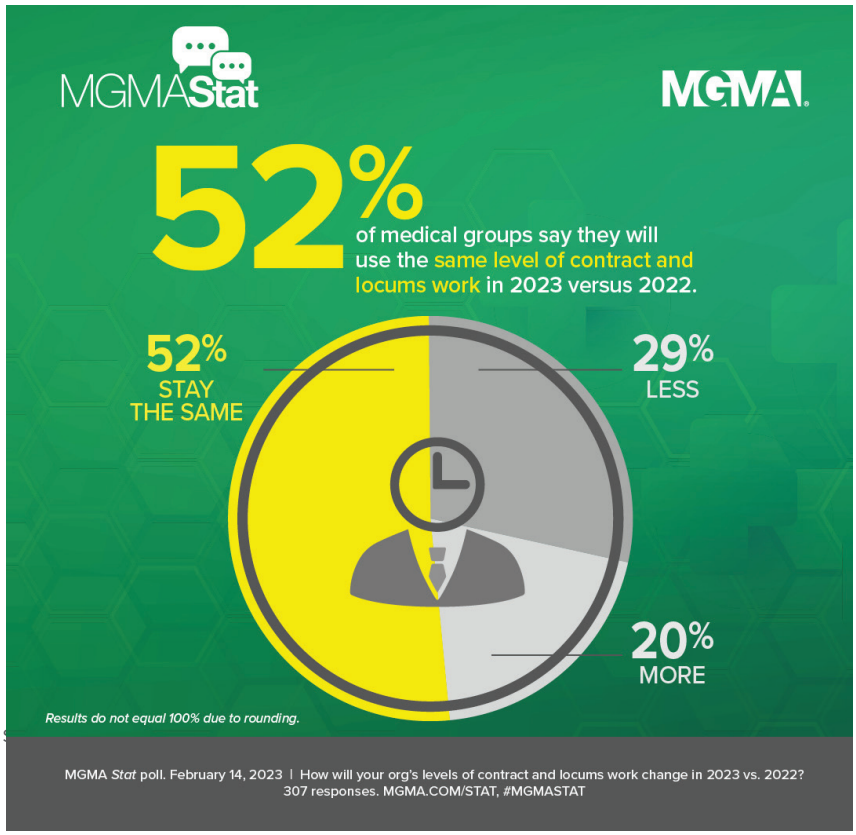
Sources: *2020* and *2023 MGMA DataDive Practice Operations*

SINGLE SPECIALTY AGGREGATE TURNOVER & HIRE RATES*	Turnover	Hire
Physicians	16.67%	28.57%
Advanced practice providers	25.00%	37.50%
Business operations support staff	33.33%	33.33%
Front office support staff	40.00%	50.00%
Clinical support staff	33.33%	34.63%
Ancillary support staff	26.59%	30.95%

*Single Specialty Aggregate combines primary care, nonsurgical and surgical single specialty practice data.

WHAT DOES IT MEAN?

- **Turnover rate**: The number of individuals who left a given position, divided by the total number of positions within a practice.
- **Hire rate**: The number of individuals hired for a given position, divided by the total number of positions within a practice.



DID YOU KNOW?

Permanent hires remained in short supply for America's medical groups, with demand for contract and locum tenens work remaining steady in the early months of 2023.

A Feb. 14, 2023, MGMA *Stat* poll asked medical group leaders how their levels of contract and locum tenens work would change in 2023 versus 2022. A solid majority (52%) said they expect those levels to stay the same compared to last year, while almost 3 in 10 (29%) expect to use less contract/locums work, and only 20% reported an expected increase in the year ahead.

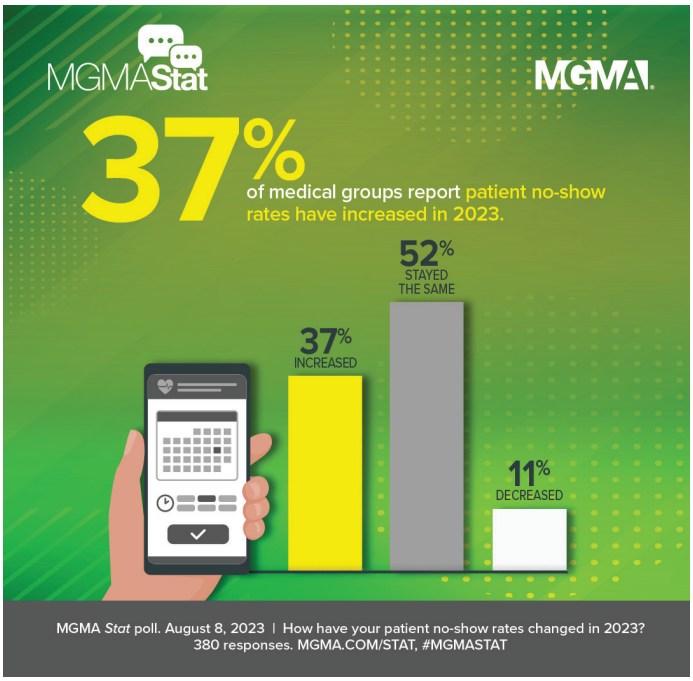
* The figures reported do not add up to 100% due to rounding.

MGMA *STAT*: PATIENT NO-SHOWS HOLDING STEADY AT MEDICAL GROUPS IN 2023

About one-third of medical groups have seen an uptick in their patient no-show rates thus far in 2023, with most practice leaders reporting they've kept this metric mostly unchanged despite staffing and financial challenges.

An Aug. 8, 2023, MGMA *Stat* poll found that **52% of medical groups reported their patient no-show rates had stayed the same so far this year compared to 2022**, while 37% reported an increase and 11% told MGMA they saw a decrease in their no-show rates. The poll had 380 applicable responses.

The latest poll finds improvement in managing patient appointments versus an Aug. 2, 2022, poll that found nearly half (49%) of medical groups had experienced a jump in no-show rates through the same period in 2022.



WHAT'S WORKING TODAY

Patient access has been at the forefront of many administrative leaders' minds, either as a public safety consideration during the COVID-19 pandemic or a matter of practicality during the Great Resignation and a shortage of available staff for check-ins, checkouts and all the patient flow in between.

For the poll respondents whose no-show rates decreased, there were several common factors that drove their improved performance:

- Several medical groups credited **the implementation of robust, automated appointment reminder and confirmation text messages, emails and/or phone calls** at a certain cadence leading up to the appointment (e.g., five days, three days and/or one day prior to the visit).
- One practice leader told MGMA that the organization is implementing a new reminder system beyond the patient portal reminders.
- Several respondents noted they have new patients sign **a no-show policy to be assessed a fee** (often $25 for an office visit or $100 for a surgical appointment) or charge for a missed appointment without appropriate notice. Multiple respondents noted that they instituted new no-show fees just in the past year for non-Medicaid patients.
- Several medical practice leaders who responded to the poll noted that they were reluctant to institute a no-show fee at this time due to the degree of manual work to implement within their existing practice management (PM) system. In instances where continued no-shows occur despite the automated reminders, some respondents noted that they have added more direct calls to patients before reaching a point of potentially dismissing a patient after a certain number of no-shows.

However, one approach that often does not lead to improvement is **the habit of overbooking appointments to avoid empty spots on providers' schedules**. As Fred Pelzman of Weill Cornell Internal Medicine Associates recently wrote for *MedPage Today*: "Instead of trying to overbook schedules … maybe we could just do everything humanly possible to ensure that everybody gets there for the appointments that are already scheduled."

Pelzman's solution? **More communication with new patients — typically, a pre-visit phone call —** to ensure the clinic has accurate phone numbers, emails, emergency contact information and patient portal enrollment.

Pelzman isn't alone in thinking there's a better way: A group of operations administrators and desk coordination leaders from the Mayo Clinic recently shared their experience in using a pre-appointment intake (PAI) process to call patients one to three business days prior to a patient's arrival, with the goal of collecting or confirming important elements for their care, including date of birth, current medications, medical devices/implants and more. The use of the PAI process resulted in improved patient rooming times, as well as increases in medication reconciliation completion. While there ultimately were mixed results in some specialties, the pilot program did reveal opportunities to create remote work opportunities for on-site clinical support team members in a competitive labor market.

OPERATIONS

Changing how to prepare patients for outpatient appointments

By Jodell Nelson BS
Amy Van Gundy MHA
Shari Kropp MA, CSM
Michelle Holmes
Carrie Deetz
Kim Stolp
Sahil Khanna MBBS, MS
and Rachel Pringnitz MBA

The pre-appointment intake (PAI) process is a scheduled appointment to conduct a medical intake phone call one to three business days prior to the patient's arrival on campus. Before scheduled PAI appointments, calls were made in the hopes we would reach patients, resulting in our ability to connect with only 40% to 50% of patients. Implementing this change has resulted in reaching about 87%, which was a more productive use of the patient and staff's time.

The patient's appointment type drives the determining factor if they are due for an intake appointment. The appointment types that currently include a PAI appointment are new, consult, and established appointments. Practice standards require that the PAI be completed every 14 days (about two weeks) to ensure compliance with medication reconciliation in the patient chart. To provide a consistent experience for patients, the following elements are confirmed/collected by allied health staff during every PAI appointment:

- Identity
- Date of birth
- Current medications
- Allergies
- Medical devices/implants
- Prescription benefits
- Preferred pharmacy
- External primary care provider (PCP)
- Advance directive opportunities
- Benefit of patient portal enrollment
- Reminder to complete questionnaires
- Tobacco use.

This appointment also serves as an appointment reminder for the patient and allows the patient to ask any questions they may have before they arrive on campus (e.g., where to park, accessibility concerns).

The efficiencies gained by scheduling the appointments created opportunities to conduct virtual training and hire remotely for this position.

Another unique aspect of this project was creating "pods" of team members in different medical departments to work together in small groups to accomplish this work. Pod determination was based on practice metric volumes in each department. Using Teams technology and pod chats for communication, we have been able to support multiple departments and complete a standardized intake. This effort has been FTE neutral pre- and post-go-live. We have transitioned some of the resources from clinical trained nurses to non-licensed delegates, which has allowed our nursing team to work at the top of their licensure.

Illustration produced via DALL·E with prompt written by MGMA staff.

LEARN MORE

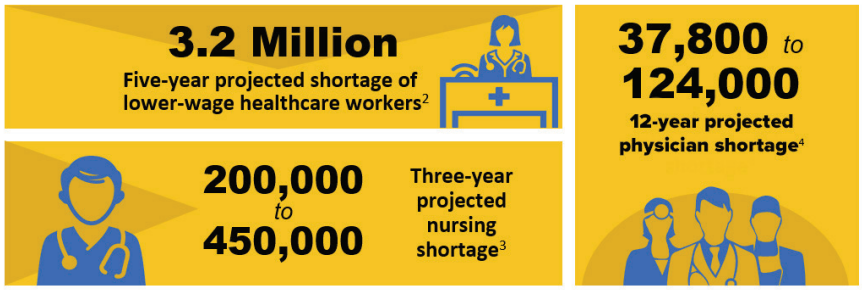
- **Click the image above** to read the full article on Mayo Clinic's pre-appointment intake process improvements.
- **Click the podcast image on the right** for a recent MGMA Insights episode on working with noncompliant patients.

DON'T LET THE LABOR SHORTAGE HURT YOUR PATIENT ACCESS

The Great Resignation. The Big Quit. The Great Reshuffle. Call it what you will, but there's no denying the lingering impact of COVID-19 on the workforce. Every industry experienced staffing shortages, with more than 10 million job openings across the United States at one point.[1]

BY STEVE MCMILLEN, MHA, AND ANNA BERENBEYM, MBA

The healthcare sector has been especially hard hit: Health systems are running on razor-thin labor margins. From contact centers to operating rooms, from the front desk to the back office, from X-ray technicians to orthopedic surgeons, seemingly every area of a health system is desperate for more workers.



The labor shortage is impacting access to care so drastically that most health systems have had to reduce hours or adjust service-level expectations. Ambulatory leaders have begun to accept that their practices won't be able to answer phones quickly, respond to patient messages efficiently, or fill schedules fully — and in the worst-case scenario, they will have to limit capacity until more staff are available.

Recent examples are plentiful, including at several organizations we've worked with:

- A leading academic medical center is so short-staffed in its outpatient radiology centers that **it stopped contacting patients to schedule orders received. Now staff wait for prospective patients to call them, amounting to a potential revenue loss in the millions of dollars.**
- A nationally ranked pediatric health system's front desk shortage is so extreme, it **consolidated clinics to maintain appropriate staffing — forcing physicians to reduce their clinic time**.
- A county health system is struggling so profoundly to retain centralized employees that **phone wait times routinely exceed an hour at the beginning of the week**.

Instances such as these can be avoided. The above examples are the outcome of health systems being reactive to the labor shortage. Proactive systems have been purposeful about how they position technology and processes to reduce the impact of fewer staff.

THE SHIFT TO PROACTIVE PATIENT ACCESS

Amid the labor shortage, healthcare organizations should focus on three primary strategies that will help them increase volumes and revenue, improve patient access and expedite patient communication with their care team despite being short-staffed.

- Strategy 1: Implement patient self-service tools: Give patients the opportunity to independently take care of their health needs at their convenience.
- Strategy 2: Reduce touches per appointment: Operational improvements can eliminate extra work for staff.
- Strategy 3: Expand patient outreach: Contacting the patient before the patient needs to contact their care provider can minimize extra work and urgent patient care coordination.

1. IMPLEMENT PATIENT SELF-SERVICE TOOLS

Tasks such as purchasing groceries or scheduling a flight are completed with the touch of a button on a smartphone. Accessing care can be just as easy. The rapid growth in healthcare technology should encourage organizations to reevaluate the role of tech in the patient journey. Self-serve solutions exist for most needs, from enhancements to existing EHRs to the addition of third-party, bolt-on software. Allowing patients to independently access care is a patient satisfier and benefits healthcare organizations by reducing the need for staff to perform manual duties, thereby optimizing operations and creating efficient workflows for care. A seamless, integrated, and navigable patient journey is achievable in several tech-enabled areas of healthcare organizations.

2. REDUCE TOUCHES PER APPOINTMENT

Despite the advantages offered by self-service tools, health systems have been slow to adopt them — even throughout the pandemic. Whether the limitations are technical, cultural or process-related, the reality is that not all organizations can offer self-service to patients. That doesn't mean they lack opportunities to be faster, more efficient and smarter with pre-access functions.

Proactive health systems have focused on creating lean, patient-friendly processes that reduce or remove the administrative burden from common pre-access tasks such as scheduling an appointment, communicating with the care team, ordering and managing a referral or requesting a prescription. With a bit of up-front work, clinics can easily reduce pre-access staffing needs by 10% to 25%.

Contact center effectiveness

Take, for example, a contact center that fields scheduling and messaging calls for a medical group. Regardless of the age, maturity or scope of the contact center, leadership teams tend to concentrate more on reducing staff than on reducing calls. Some patients call their clinic as many as five times per appointment scheduled.[6] Although this includes clinical questions and refill requests, the volume illustrates contact center inefficiency.

Using a combination of refined workflows, added services and supplemental communication channels, contact centers can reduce their incoming calls to best practice levels. Tactics may include:

- Implementing a robust internal knowledge management system that allows representatives to answer care-related and administrative questions and schedule appointments without messaging the clinic
- Instituting open appointment availability with minimal scheduling restrictions
- Expanding centralized services to include nurse triage, after-hours answering service, referral coordination and prescription refill support to promote first-call resolution and avoid phone tag between the contact center, practice, and patient
- Adding communication channels beyond the phone, such as chat, chatbot, patient portal and e-visits to expedite requests.

Template optimization

Many medical groups have focused on optimizing their EHR to find efficiency in workflows. Scheduling an appointment should be made as easy as possible for staff. Template optimization is typically the first step in this process. By optimizing templates, clinics can make use of the EHR's automated scheduling tools and reduce complexity in matching patients to the appropriate provider, visit type and time.

Optimizing templates is best achieved by beginning with group–wide guiding principles that serve as guardrails for specialty-specific design. Guiding principles allow specialties the flexibility needed for their individual nuances while still conforming to a system standard that promotes patient access and improves automation of appointing. Guiding principles may include concepts such as:

- Number of allowable visit types
- Accessibility of templates to staff outside of the practice (e.g., contact center, emergency department) and use of guided scheduling to drive effective scheduling
- Use of blocks, session limits/quotas and other EHR tools
- Openness of the template.

With these principles in place, specialties can design their templates in a way that reduces the time and training required to book an appointment. Additionally, the templates can more easily be translated to online scheduling. With simplified templates, clinics can reduce the time staff spend scheduling appointments, which can ease the burden of being short-staffed, especially in a centralized environment.

Point-of-service scheduling

Specialty practices are often resistant to having other staff schedule into their physician templates. Even a medical group's contact center is often perceived as posing too much of a risk for scheduling errors. But in light of the staffing shortage, this attitude needs to change. If templates are set up appropriately, practices should allow anyone — practice staff, a contact center, patients, referring providers and staff in other areas of the health system — to book most appointments into their schedules, given the appropriate parameters.

Take, for example, a surgery practice that treats 10,000 new patients per year. If 50% of these new patients are referred internally from the medical group's primary care practices, letting those staff schedule the new-patient appointment upon checkout can save 5,000 instances of phone tag. Expanding this to external practices using digital applications (including some native to certain EHRs) can even further reduce the time staff needs to schedule new patients.

These strategies have common themes: empower the patient, support the employee, automate the process, and simplify the rules.

3. EXPAND PATIENT OUTREACH

Communication can also reduce unnecessary patient communication and appointments. By reaching out to patients before they require an urgent appointment, health systems can save time, resources and prevent "fire drills," all while providing seamless service to patients.

Outreach about patient care can help manage last-minute demand. Conducting emergency room, hospital, urgent care or surgical follow-up calls can help address patients' clinical questions before they schedule an unnecessary visit. When a five-minute call can save a 20-minute visit — and the registration, scheduling, check-in and checkout processes that coincide with the visit — it gives staff more flexibility.

The same outcome can be achieved for health maintenance checks for preventive care, chronic care or clinic/emergency room "frequent fliers." While outreach requires valuable staff time, it will equate to more time saved later.

These strategies may not always lead to a reduction in visits, but a switch from an inbound call to an outbound call is also valuable. Outbound calls can be made during times of reduced staffing needs — typically in the afternoons later in the week — whereas inbound calls are not as predictable and require increased staffing. As a general rule of thumb, 1.0 FTE spent on outbound calls can replace 1.5 to 2.0 FTEs spent on or waiting for inbound calls.

Technology can automate this outreach and reduce staffing needs as well. With the increased focus on population health, value-based care and tightening margins, technology companies have a heightened emphasis on solutions that automate outbound capabilities. Population health companies have created tools with predictive analytics that can help organizations proactively provide care to patients before they require urgent or emergent care. Combining these tools with automated outbound texting, phone, or email platforms allows these outbound needs to be met with little or no staff.

Even without the sophistication of a population health tool, health systems with phone personnel should invest in automated dialers that conduct outbound calls on behalf of staff and alert them when the patient picks up. Outbound staff can be significantly more efficient when they don't have to scrub lists, dial numbers and wait for patients to answer.

Strategy in action: Contra Costa Health Services (CCHS)

CCHS, a county health system in California serving the surrounding area's most vulnerable populations, offers an example of how a team can be proactive about patient access strategies despite a decline in staffing. CCHS and ECG Management Consultants have been working together to address ongoing challenges with patient access, including long wait times on the phone and poor appointment availability.

After a rapid assessment, ECG and CCHS developed and implemented a future-state model for centralized services and patient access operations that supported and balanced the needs of patients, physicians, clinics and the county while reducing the burden on administrative staff. Implementation of this model included:

- Optimizing templates, including expanding capacity, introducing guided scheduling, and removing barriers to access
- Offering online scheduling in primary care and all specialty departments
- Reconfiguring contact center staffing and introducing shrinkage reduction and productivity tracking management
- Streamlining and optimizing the referral management and new-patient specialty scheduling processes
- Optimizing and digitizing clinic-based processes, including preregistration, check-in and checkout
- Introducing strategies to reduce and streamline clinic cancellations, patient rescheduling and no-shows
- Configuring the telephony platform, online scheduling, electronic registration, and other digital tools to expand self-service and consumer-centric options.

Outcomes

These optimization efforts led to increased revenue, decreased costs and an improved patient experience.

Increased revenue: Provider productivity

The contact center was able to keep provider schedules full by improving the scheduling process, including introducing online scheduling, revamping the referral management process, using additional communication channels, simplifying provider templates, and optimizing use of its EHR to better organize work. This led to a 2.7% increase in provider fill rate in the first six months, which equated to $2.2 million in additional annual revenue.

Decreased costs: Labor efficiencies

Three separate patient access teams were combined to reduce fragmentation and promote efficiency in completing tasks. To improve employee productivity, CCHS implemented shrinkage monitoring and coaching protocols. CCHS also updated the training program and created more efficient processes through workflow and template optimization sprints. These efforts led to a reduced reliance on staff, including:

- 4.1% decrease in inbound call volume, primarily due to online appointment scheduling
- 5.2% decrease in time employees spend on the phone
- 4.0% improvement in scheduling efficiency from cross-training staff, introducing automation and standardizing workflows.

Improved patient experience: Digital options

Patients can now schedule or register for an appointment online. Just six months after its launch, 18% of new CCHS patients are scheduled online. This digitization of patient access services has begun CCHS's efforts to empower the consumer and establish a digital front door. Additionally, improvements to the contact center have reduced phone wait times by more than 25%.

RETHINKING THE APPROACH TO PATIENT ACCESS

The labor shortage is not going away any time soon. Trying to wait out the storm, employ temporary labor or reduce clinic capabilities are not financially viable options. Health systems that are thoughtgul about their patient access strategy are able to do more with less if they invest in the right technology and operational improvements.

Across the front desk staff, the outreach team, the contact center and the clinical team, every area of the clinic can be smarter about how they approach their communication and pre-access functions with patients. Just as the pandemic forced medical groups to rethink their approach to patient care, the labor shortage should make us all rethink our approach to patient access.

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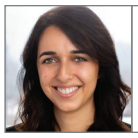

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- **"Chronic care management: Implementation and reimbursements"** — Insight article on the trend toward more quality measurement and CCM implementation
- **2023 Leaders Conference** — Oct. 22-25 in Nashville, Hosted by MGMA — Powered by You

The MGMA data and content teams wish to thank the medical practices that contributed their insights to the *2023 Practice Operations* survey, as well as the thousands of healthcare leaders who participate in MGMA *Stat*.

THINKING FORWARD

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